| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0000 | This visit was for the Investigation of Complaint IN00086657.<br><br>Complaint IN00086657: Substantiated - Federal/State deficiencies related to the allegations are cited at F272, F279, F282, F309, and F441.<br><br>Unrelated deficiencies cited.<br><br>Survey dates: March 8 and 9, 2011<br><br>Facility number: 001145<br>Provider number: 155616<br>AIM number: 200120200<br><br>Survey team: Jennie Bartelt, RN<br><br>Census bed type:<br>SNF/NF: 74<br>Residential: 17<br>Total: 91<br><br>Census payor type:<br>Medicare: 12<br>Medicaid: 54<br>Other: 25 | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Total: 91<br><br>Sample: 7<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed 3-15-11 Cathy Emswiller RN | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0176 SS=D | Based on observation, interview, and record review, the facility failed to ensure a resident who was self-administering respiratory medications had assessment and physician orders related to the self administration of the medication. The deficient practice affected 1 of 1 resident reviewed related to self administration of medication in a sample of 7. (Resident B)<br><br>Findings include:<br><br>During the Initial Tour on 3/8/11 at 6:50 p.m., Resident B was observed in bed. A hand-held inhaler and a nebulizer treatment machine were observed on the bedside table next to the resident. During interview at this time, the resident indicated he had just used his inhaler, motioned to the nebulizer treatment machine, and indicated he would be using his nebulizer treatment shortly. The resident indicated he was able to manage the medications himself. The resident indicated he moved | F0176 | **F176 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE**<br>It is the practice of Landmark Nursing & Rehabilitation to assure an individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>I. Resident B was assessed for the ability to self administer medications. This assessment was completed by R.N. in conjunction with IDT. This assessment was placed in Resident B's clinical record. Resident B's care plan was updated to reflect the self administration of medications. Resident B was provided with a calendar to document the provision of self medications readily accessible to nurses to review.<br>II. All Residents were reviewed for the desire to self administer medications. All residents who verbalized the desire to self administer medications will be assessed and care plans will be updated accordingly.<br>III. Self Medication Policy was reviewed by QA and found to be appropriate. All nurses were educated on the Self Medication Policy | 04/08/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | into the facility from "upstairs" (assisted living section of the facility) about a week earlier.<br><br>Review of a list of "Interviewable Residents" provided by the Director of Nursing after the Entrance Conference indicated Resident B was interviewable.<br><br>The clinical record for Resident B was reviewed on 3/8/11 at 11:00 p.m. The record indicated the resident was admitted to the facility on 3/1/11. The resident's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease).<br><br>Physician's orders for 3/1/11 through 3/31/11 included, but were not limited to, "Duoneb 2.5 - 0.5 mg 3 ml/sol [medication for prevention of bronchospasm], 1 vial every 4 hours as needed SOA [shortness of air] /wheezing" and "Ventolin HFA [bronchodilator medication] 90 mcg [micrograms], | | IV. The Care Plan Coordinator will maintain the care plans for those residents desiring to self administer medications. These care plans will be reviewed no less frequently than quarterly and with any significant change in status. During the care plan review process, the self administration of medication assessment will be updated to reflect each resident's current status. The Care Plan Coordinator will report to QA monthly for 3 months and then quarterly.<br>COMPLETION DATE: 04/08/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Take 2 puffs every 4 hours as needed, SOA."<br><br>The Medication Administration Record for March 2011 indicated the Duoneb had been administered one time on 3/8/11 at 1:00 [a.m. or p.m.] not indicated.<br><br>The Assessments section of the resident's record failed to indicate an assessment related to self-administration of medications.<br><br>During interview on 3/9/11 at 2:30 p.m., the Director of Nursing (DON) indicated the facility did not have a written policy related to self-administration of medication. The DON provided copy of a blank form entitled "Self Administration of Medication Assessment" and indicated the instructions on the form should be followed for residents self administering medications. The instructions on the form indicated, "Complete assessment upon resident request to | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | self administer medications. There must be a physician's order to self administer and the order must be specific as to which medication(s). Complete re-assessment quarterly or with significant changes in the resident's condition." The DON indicated to her knowledge, no residents administered medications themselves. The DON indicated Resident B must have administered his own medications when he was on "residential" (assisted living section of facility) and had continued to do so.<br><br>Physician's orders failed to include an order for the resident to self-administer the medication.<br><br>3.1-11(a) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0272 SS=D | Based on observation, record review, and interview, the facility failed to ensure wounds were assessed and reassessed on a weekly basis for 2 of 4 residents reviewed related to wound care in a sample of 7. (Residents D and G)<br><br>Findings include:<br><br>1. During the Initial Tour on 3/8/11 at 6:50 p.m., Resident D was interviewed. The resident indicated she was very hard of hearing and requested communication with notes written on paper she provided. She indicated she had a boil on her leg and pointed to the left leg above the knee. The resident closed the door to her room, and she pulled her pants below the knees to show the dressing on the wound. A Telfa pad was observed above the left knee.<br><br>The clinical record for Resident D was reviewed on 3/8/11 at 10:55 p.m. The resident's annual | F0272 | **F272 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS**<br>It is the practice of Landmark Nursing & Rehabilitation to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>I. Complete skin checks and wound assessments were completed for Resident D and Resident G by licensed nurses. These wound assessments continue to be done weekly and documented in the Residents' clinical records on the Weekly Wound Evaluation Flow Record by licensed nurses.<br>II. Complete skin checks will be completed on all residents. All wounds will be identified and assessed by licensed nurse. These assessments will be documented in the residents' clinical records on the Weekly Wound Evaluation Flow Record. Weekly reassessment by licensed nurses will be ongoing and documented in the residents' clinical records on the Weekly Wound Evaluation Flow Record.<br>III. LPN #12 will be reeducated on wound assessment, physician's orders and notification of physician regarding changes in skin condition. Wound Evaluation and Treatment Policy was reviewed by | 04/08/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Minimum Data Set assessment dated 7/9/10 indicated the resident was independent in cognitive skills for daily decision-making, could understand, and was able to make herself understood.<br><br>A Nurse's Note dated 2/17/11 at 12:30 p.m., indicated, "N.O. [new order] noted & faxed for warm compress to boil on L [left] thigh BID [twice daily] then apply TAO [triple antibiotic ointment] & cover [symbol for with] telfa. Area around boil reddened, scant amt [amount] of clear drainage noted. Will cont [continue] to monitor." No further documentation since this note was indicated in the Nurse's Notes section of the clinical record.<br><br>An Interdisciplinary (IDT) Progress Note dated 2/18/11 (no time indicated), indicated, "Resident [symbol for with] boil present to L thigh & orders received for compresses. See NN [Nurse's Note] of 2/17/11." No further | | QA and found to be appropriate.<br>All nurses will be reeducated on the Wound Evaluation and Treatment Policy. Nurses will complete skin checks as prescribed by physicians. The results of these skin checks will be documented on the back of the resident's Treatment Administration Record. C.N.A.'s will continue to complete skin documentation with each shower and turn in completed shower sheets to nurse. Nurse will review these sheets for any changes in skin condition not identified through prescribed skin checks. Should a wound be identified by any means, the nurse will assess the wound and document the assessment on Weekly Wound Evaluation Flow Record<br>IV. The DON will review shower sheets daily. The DON will oversee the IDT review of wounds no less often than weekly. This review will include but not be limited to visualization of the wound and wound assessment documentation. The DON will report to QA monthly for 3 months and then quarterly.<br>V. COMPLETION DATE: 04/08/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | documentation since the note was indicated in the Interdisciplinary Progress Note section of the clinical record.<br><br>The Medication Record and Weekly Skin Check Sheet for February 2011 indicated no skin assessment was completed as scheduled on 2/19/11. The Weekly Skin Check Sheet indicated the resident had an "Open area: Old" on the right thigh on 2/26/11 and an unsigned, undated "Weekly Skin Check Sheet" in the Medication Record Binder at the medication cart for Resident D's hall indicated: "Other: boil R [right] thigh."<br><br>During interview on 3/8/11 at 9:45 p.m., the Director of Nursing (DON) indicated the facility does not have a specific wound nurse, but she or the Assistant Director of Nursing (ADON) look at wounds once a week. She indicated documentation would be in IDT notes or on skin sheets on the TAR | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | [Treatment Administration Record].<br><br>On 3/9/11 at 12:50 p.m., LPN #6 was observed providing the treatment to Resident D's left thigh. Resident D pulled her pants below the knees, and the dressing on the left thigh indicated 3/8/11, 8:15 p.m. LPN #6 removed the soiled dressing. The resident indicated, "It looks like it's filling back up." The nurse indicated there was no drainage. The wound was observed to be white/yellow in the center surrounded by a red rim and dark around the edges under the skin. During interview at this time, LPN #6 indicated documentation should be in the record about the wound size, and she indicated she estimated the current size by placing her thumb to the first knuckle of her middle finger to show the approximate size of the wound.<br><br>During interview on 3/9/11 at 2:30 p.m., the DON indicated the facility | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | did not have written wound care policies. She indicated related to assessment of the wound that a nurse would write what she sees. The DON showed a Weekly Wound Evaluation Flow Record for another resident and indicated she would expect to see the information on that form on a wound assessment. Review of the Flow Record indicated information including stage, length, width, and depth, presence of undermining, exudate type and amount, tissue description, and surrounding skin color and type.<br><br>During interview on 3/9/11 at 4:45 p.m., the DON indicated she had spoken with a nurse, who told the DON she had measured the resident's wound when it was first noted, but the nurse forgot to write it down. The DON indicated she could find no documentation to indicate the wound had been assessed since 2/17/11. The DON indicated she could not find a | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Weekly Wound Evaluation Flow Record for Resident D's wound.<br><br>2. The clinical record for Resident G was reviewed on 3/8/11 at 9:40 p.m. The resident's diagnoses included, but were not limited to, unspecified peripheral vascular disease and unspecified venous insufficiency.<br><br>Weekly Skin Check Sheets for February and March 2011 indicated the following: on 2/5, 2/12, and 2/26/11, the assessment indicated the resident had "Open area: Old." Documentation failed to indicate a skin assessment was completed on 2/19/11. Documentation on 3/5/11 indicated "Skin Intact." Weekly Wound Evaluation Flow Records from 1/19/11 through 3/9/11 indicated the resident was being treated for a non-pressure ulcer to the left ankle.<br><br>A physician's order was received on 2/22/11 for "Cleanse R [right] ankle | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | [symbol for with] NS [normal saline] apply Aquacel AG [alginate] cover [symbol for with] Versiva X C & wrap [symbol for with] Kerlix q [every] 3 days & PRN [as needed] for soiled/dislodged."<br><br>Documentation in Nurse's Notes from 2/22/11 through date of review or on a Weekly Wound Evaluation Flow Record failed to indicate a description of the wound.<br><br>Documentation on the Medication Records for February and March 2011 next to the entry for the dressing change indicated the dressing was changed on the following dates: 2/22, 2/25, 2/26, and 2/28/11 and 3/3, 3/5, 3/6, and 3/7/11.<br><br>Nurse's Notes for 2/25/11 at 1:20 p.m., indicated, "...Tx [treatment] to bilat [bilateral] ankles completed as ordered." No other Nurse's Notes indicated information about the wound to the right ankle. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | During interview on 3/9/11 at 4:45 p.m., the DON was at the nurse's station and researched the resident's record for information about the wound. LPN #3 was seated at the nurse's station and indicated the resident had wounds come and go on both ankles with lots of changes in treatments. The DON telephoned the nurse, LPN #12, who had cared for Resident G on day shift on 3/9/11. LPN #12 indicated to the DON she provided a treatment to the resident's left ankle today but did not provide the treatment to the right ankle, because there was "nothing to treat." The DON asked LPN #12 if she had obtained a physician's order to discontinue the treatment, and LPN #12 indicated she had not contacted the physician. The DON indicated LPN#12 told her she had seen a Weekly Wound Evaluation Flow Record related to the right ankle wound, but the DON indicated she was unable to locate | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the Flow Record.<br><br>On 3/9/11, immediately after the DON completed the phone conversation with LPN #12, Resident G's right ankle was observed. The DON and LPN #3 wheeled the resident to his room and removed his white sock. Two small areas of bright red blood were on the sock. The resident's lower right leg was dark red, and the skin was shiny. Two open areas oozing clear bloody fluid were observed on the front of the right shin. A dark purplish blotch under the skin was observed on the top of the foot. No dressing was present on the resident's right ankle. The top of the outer malleolus had a dull dark red center that appeared firm and slightly depressed. No drainage was observed. LPN #3 ran her fingers over the area and indicated it was not open. The resident asked if there was pus in the wound, and LPN #3 told him there was not. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | This federal tag relates to Complaint IN00086657.<br><br>3.1-31(c)(2) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0279 SS=D | Based on observation, interview, and record review, the facility failed to ensure care was planned related to wounds for 2 of 4 residents reviewed related to wound care in a sample of 7. (Residents D and G)<br><br>Findings include:<br><br>1. During the Initial Tour on 3/8/11 at 6:50 p.m., Resident D was interviewed. The resident indicated she was very hard of hearing and requested communication with notes written on paper she provided. She indicated she had a boil on her leg and pointed to the left leg above the knee. She indicated the wound dressing was to be changed two times a day but that did not always happen. She indicated the nurse applied a triple antibiotic ointment, and the wound was painful when the nurse squeezed it. She indicated when she had boils in the past, she needed a "surgeon to cut the core | F0279 | **F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS**<br><br>It is the practice of Landmark Nursing and Rehabilitation to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>I. Care plans for Resident D and Resident G were updated to reflect current wound treatment interventions. Treatment prescriptions for Resident D and G have been reviewed and treatments are being provided as prescribed and documented on each resident's Treatment Administration Record.<br>II. Complete skin checks will be completed on all residents. All wounds will be identified and assessed by licensed nurse. The Treatment Administration Records and care plans for all residents identified as having wounds will be updated to include current wound treatment interventions.<br>III. LPN #12 will be reeducated on skin assessment, physician's orders and notification of physician regarding changes in skin condition. Wound Evaluation and Treatment Policy was reviewed by QA and found to be appropriate. All nurses will be reeducated on the provision and | 04/08/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | out." The resident closed the door to her room, and she pulled her pants below the knees to show the dressing on the wound. A Telfa pad was observed above the left knee. Written on the dressing was 3/8/11, 2:00 p.m.<br><br>The clinical record for Resident D was reviewed on 3/8/11 at 10:55 p.m. The resident's annual Minimum Data Set assessment dated 7/9/10 indicated the resident was independent in cognitive skills for daily decision-making, could understand, and was able to make herself understood.<br><br>A Nurse's Note dated 2/17/11 at 12:30 p.m., indicated, "N.O. [new order] noted & faxed for warm compress to boil on L [left] thigh BID [twice daily] then apply TAO [triple antibiotic ointment] & cover [symbol for with] telfa. Area around boil reddened, scant amt [amount] of clear drainage noted. Will cont [continue] to monitor." | | documentation of treatments as prescribed by physicians. Nurses and Care Plan Coordinator will be reeducated on policy including but not limited to the care planning of current wound treatment interventions.<br>IV. The DON will oversee the IDT review of wounds no less often than weekly. This review will include but not be limited to review of treatment administration records to assure treatments are being administered as prescribed and review and revision of care plan to reflect current wound treatment interventions. The DON will report to QA monthly for 3 months and then quarterly.<br>V. COMPLETION DATE: 04/08/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | No further documentation since this note was indicated in the Nurse's Notes section of the clinical record.<br><br>An Interdisciplinary (IDT) Progress Note dated 2/18/11 (no time indicated), indicated, "Resident [symbol for with] boil present to L thigh & orders received for compresses. See NN [Nurse's Note] of 2/17/11." No further documentation since the note was indicated in the Interdisciplinary Progress Note section of the clinical record.<br><br>During interview on 3/8/11 at 9:45 p.m., the Director of Nursing (DON) indicated the facility does not have a specific wound nurse, but she or the Assistant Director of Nursing (ADON) look at wounds once a week. She indicated documentation would be in IDT notes or on skin sheets on the TAR [Treatment Administration Record].<br><br>Documentation related to care | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | currently in effect for Resident D was in a plastic sleeve in the clinical record. The current Care Plans of failed to indicate a plan for care of the skin related to the boil on the resident's left thigh.<br><br>Documentation on the Medication Records for February 2011 and March 2011 indicated the treatment ordered for the boil on Resident D's left thigh was planned once on the 6:00 a.m. to 2:00 p.m. shift and once on the 2:00 p.m. to 10:00 p.m. shift.<br><br>During interview on 3/9/11 at 2:30 p.m., the DON indicated the facility did not have written wound care policies.<br><br>During interview on 3/9/11 at 4:45 p.m., the DON indicated she had spoken with the nurse who indicated she had measured the resident's wound when it was first noted but forgot to write it down. The DON indicated she could find | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | no documentation to indicate the wound had been assessed since 2/17/11. The DON indicated she could not find a Weekly Wound Evaluation Flow Record for Resident D's wound.<br><br>2. The clinical record for Resident G was reviewed on 3/8/11 at 9:40 p.m. The resident's diagnoses included, but were not limited to, unspecified peripheral vascular disease and unspecified venous insufficiency.<br><br>Weekly Skin Check Sheets for February and March 2011 indicated the following: on 2/5, 2/12, and 2/26/11, the assessment indicated the resident had "Open area: Old." Documentation failed to indicate a skin assessment was completed on 2/19/11. Documentation on 3/5/11 indicated "Skin Intact." Weekly Wound Evaluation Flow Records from 1/19/11 through 3/9/11 indicated the resident was being treated for a non-pressure ulcer to | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the left ankle.<br><br>A physician's order was received on 2/22/11 for "Cleanse R [right] ankle [symbol for with] NS [normal saline] apply Aquacel AG [alginate] cover [symbol for with] Versiva X C & wrap [symbol for with] Kerlix q [every] 3 days & PRN [as needed] for soiled/dislodged."<br><br>Documentation in Nurse's Notes from 2/22/11 through date of review or on a Weekly Wound Evaluation Flow Record failed to indicate a description of the wound.<br><br>Documentation on the Medication Records for February and March 2011 next to the entry for the dressing change indicated the dressing was changed on the following dates: 2/22, 2/25, 2/26, and 2/28/11 and 3/3, 3/5, 3/6, and 3/7/11.<br><br>Nurse's Notes for 2/25/11 at 1:20 p.m., indicated, "...Tx [treatment] to | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | bilat [bilateral] ankles completed as ordered." No other Nurse's Notes indicated information about the wound to the right ankle.<br><br>The resident's Health Care Plan indicated a problem of "Venous Stasis Ulcer to the left ankle," dated 2/3/10, with most recent Goal date of 1/26/11. Documentation failed to indicate a plan related to care of the right ankle.<br><br>During interview on 3/9/11 at 4:45 p.m., the DON researched the resident's record for information about the wound. LPN #3 was seated at the nurse's station and indicated the resident had wounds come and go on both ankles with lots of changes in treatments. The DON telephoned the nurse, LPN #12, who had cared for Resident G on day shift on 3/9/11. LPN #12 indicated to the DON she provided a treatment to the resident's left ankle today but did not provide the treatment to the right ankle, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | because there was "nothing to treat." The DON asked LPN #12 if she had obtained a physician's order to discontinue the dressing, and LPN #12 indicated she had not contacted the physician.<br><br>Resident G's right ankle was observed on 3/9/11 after the DON completed the phone conversation with LPN #12. The DON and LPN #3 wheeled the resident to his room and removed his white sock. Two small areas of bright red bloody drainage were on the sock. The resident's lower right leg was dark red, and the skin was shiny. Two open areas oozing clear bloody fluid were observed on the front of the right shin. A dark purplish blotch under the skin was observed on the top of the right foot. No dressing was present on the resident's right ankle. The top of the right outer malleolus had a round area with a dull dark red center that appeared firm and slightly depressed. No drainage | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | was observed. LPN #3 ran her fingers over the area and indicated it was not open. The resident asked if there was pus in the wound, and LPN #3 told him there was not. LPN #3 indicated she would obtain treatment orders and care for the two new wounds on the resident's shin.<br><br>This federal tag relates to Complaint IN00086657.<br><br>3.1-35(d)(2)(B) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0282 SS=D | Based on record review and interview, the facility failed to ensure the resident's plan of care related to use of a specialized drinking cup was implemented for 1 of 1 resident reviewed related to use of a special cup in a sample of 7.<br><br>Findings include:<br><br>The clinical record for Resident G was reviewed on 3/8/11 at 9:40 p.m.<br><br>Nurse's Notes for 2/22/11 at 10:30 a.m., indicated, "Spoke [symbol for with] daughter earlier....She was concerned about him getting fluids. Does have a special cup he likes to use. He does drink from a regular cup or glass [symbol for with] straw [without] any difficulty....She complained that his 'special cup' wasn't always @ bedside and that the nurse on this past Friday did not know that the cup @ the desk was his. This nurse was verified to be a | F0282 | **F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN**<br>It is the practice of Landmark Nursing & Rehabilitation to assure the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>I. Resident G was reassessed for adaptive equipment needs by occupational therapist. Resident G's care plan and C.N.A. assignment sheet were updated to reflect current adaptive equipment needs.<br>II. All residents will be reviewed for the use of nutrition/hydration adaptive equipment. Care plans and C.N.A. assignment sheets will be updated to reflect current adaptive equipment needs for those residents requiring nutrition/hydration adaptive equipment.<br>III. An Adaptive Equipment Policy was drafted, reviewed by QA and found to be appropriate. Therapy, Nursing and Dietary departments will be educated on policy<br>IV. The Care Plan Coordinator will review each resident's care plan no less often than quarterly and with any significant change in condition. All adaptive equipment needs will | 04/08/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | [lined out word] realatively [sic] new nurse here. Assured her that this nurse would be made aware of his 'special cup.' This is on CNA assignment sheets now for quite sometime. Suggested that we place his name on his cup so all would be aware that this cup was his. She agreed. Cup marked...."<br><br>A Therapy Response to Nursing Communication, dated 7/13/10, indicated, "Rsd [resident] on OT [occupational] and PT [physical therapy] caseload." The "Comments" section indicated, "Utilize cut out cups with handles on all trays. Therapy ordered cup & cup arrived today. Dietary notified of new A.D. [assistive device]."<br><br>An Occupational Therapy Progress Report, signed electronically by the Occupational Therapist on 7/20/10 indicated, "Caregiver Education: Use of 2-hand cup to increase independence with drinking | | be reviewed and modifications will be made to the care plan as needed to reflect current adaptive equipment needs. The DON or designee will review new orders daily and revise C.N.A. assignment sheets as needed to assure current adaptive equipment needs are communicated to care giving staff. The DON will report to QA monthly for 3 months and then quarterly.<br>V. COMPLETION DATE: 04/08/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | promoting hydration through day."<br><br>The Care Plan Checklist originally dated 10/7/10, indicated nutrition problems including, but not limited to, "dehydration diagnosis." Goals with dates of 1/7/11, 2/4/11, and 4/ (no day indicated)/11, included, but were not limited to, "Resident will have no S/S [signs and symptoms] dehydration." Interventions included, but were not limited to, "Adaptive equipment: nosey 2 handle sippy cup."<br><br>During interview on 3/9/11 at 2:00 p.m., Occupational Therapist (OT) #4 indicated Resident G was to have a special cup on his tray and at the bedside. The OT indicated he would review the documentation related to the assessment of the resident for the cup. During interview on 3/9/11 at 2:20 p.m., the OT indicated the resident's use of the nosey cup was related to increasing hydration. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | This federal tag relates to Complaint IN00086657.<br><br>3.1-35(g)(2) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0309 SS=D | Based on observation, record review, and interview, the facility failed to ensure wounds were assessed and wound care needs planned and implemented for 2 of 4 residents reviewed related to wound care in a sample of 7. (Residents D and G)<br><br>Findings include:<br><br>1. During the Initial Tour on 3/8/11 at 6:50 p.m., Resident D was interviewed. The resident indicated she was very hard of hearing and requested communication with notes written on paper she provided. She indicated she had a boil on her leg and pointed to the left leg above the knee. She indicated the wound dressing was to be changed two times a day but that did not always happen. She indicated the nurse applied a triple antibiotic ointment, and the wound was painful when the nurse squeezed it. She indicated when she had boils in the past, she | F0309 | **F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** It is the practice of Landmark Nursing and Rehabilitation to assure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. I. Complete skin checks and wound assessments were completed for Resident D and Resident G by licensed nurses. These wound assessments continue to be done weekly and documented in the Residents' clinical records on the Weekly Wound Evaluation Flow Record by licensed nurses. Treatment orders for Resident D and Resident G were reviewed by IDT. Treatments are being delivered as prescribed and documented on each resident's Treatment Administration Record. Care plans for Resident D and Resident G were updated to reflect current wound treatment interventions. II. Complete skin checks will be completed on all residents. All wounds will be identified and assessed by licensed nurse. This assessment will be documented in the residents' clinical records on the Weekly Wound Evaluation Flow Record. Weekly reassessment by licensed nurses is ongoing and | 04/08/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | needed a "surgeon to cut the core out." The resident closed the door to her room, and she pulled her pants below the knees to show the dressing on the wound. A Telfa pad was observed above the left knee. Written on the dressing was 3/8/11, 2:00 p.m.<br><br>The clinical record for Resident D was reviewed on 3/8/11 at 10:55 p.m. The resident's annual Minimum Data Set assessment dated 7/9/10 indicated the resident was independent in cognitive skills for daily decision-making, could understand, and was able to make herself understood.<br><br>A Nurse's Note dated 2/17/11 at 12:30 p.m., indicated, "N.O. [new order] noted & faxed for warm compress to boil on L [left] thigh BID [twice daily] then apply TAO [triple antibiotic ointment] & cover [symbol for with] telfa. Area around boil reddened, scant amt [amount] of clear drainage noted. | | documented in the residents' clinical records on the Weekly Wound Evaluation Flow Record. All wound treatment orders will be reviewed. The Treatment Administration Records and care plans for all residents identified as having wounds will be updated to include current wound treatment interventions. III. LPN #6 will be reeducated on the provision of clean dressing changes, infection control practices including but not limited to the use of PPE, and wound assessment. LPN #12 will be reeducated on skin assessment, physician's orders and notification of physician regarding changes in skin condition. Wound Evaluation and Treatment Policy (includes Clean Dressing Change Procedure) was reviewed by QA and found to be appropriate. All nurses will be reeducated on the Clean Dressing Change and Wound Evaluation and Treatment Policies. Care Plan Coordinator will be reeducated on care planning of current wound treatment interventions. All nurses will be reeducated on the provision and documentation of treatments as prescribed by physicians. Nurses will complete skin checks and treatments as prescribed by physicians. The treatments will be documented as rendered on the front of each resident's Treatment Administration Record. Results | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Will cont [continue] to monitor." No further documentation since this note was indicated in the Nurse's Notes section of the clinical record.<br><br>An Interdisciplinary (IDT) Progress Note dated 2/18/11 (no time indicated), indicated, "Resident [symbol for with] boil present to L thigh & orders received for compresses. See NN [Nurse's Note] of 2/17/11." No further documentation since the note was indicated in the Interdisciplinary Progress Note section of the clinical record.<br><br>The Medication Record and Weekly Skin Check Sheet for February 2011 indicated no skin assessment was completed as scheduled on 2/19/11. The Weekly Skin Check Sheet indicated the resident had an "Open area: Old" on the right thigh on 2/26/11 and an unsigned, undated "Weekly Skin Check Sheet" in the Medication Record Binder at the medication cart for | | of skin checks will be documented in the residents clinical record. C.N.A.'s will continue to complete skin documentation with each shower and turn in completed shower sheets to nurse. Nurse will review these sheets for any changes in skin condition not identified through prescribed skin checks. Should a wound be identified by any means, the nurse will assess the wound and document the assessment on Weekly Wound Evaluation Flow Record. A competency checklist for Clean Dressing Changes was drafted and approved by QA. IV. The DON will review shower sheets daily. The DON will oversee the IDT review of wounds no less often than weekly. This review will include but not be limited to visualization of the wound, review of treatment orders, review of treatment administration records to assure treatments are being administered as prescribed, wound assessment documentation and care planning of current wound treatment interventions. The DON or designee will complete Clean Dressing Change Competency Checklists with all nurses initially and then no less often than annually thereafter. The DON will report to QA monthly for 3 months and then quarterly. V. COMPLETION DATE: 04/08/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Resident D's hall indicated: "Other boil R [right] thigh."<br><br>During interview on 3/8/11 at 9:45 p.m., the Director of Nursing (DON) indicated the facility does not have a specific wound nurse, but she or the Assistant Director of Nursing (ADON) look at wounds once a week. She indicated documentation would be in IDT notes or on skin sheets on the TAR [Treatment Administration Record].<br><br>Documentation related to care currently in effect for Resident D was in a plastic sleeve in the clinical record. The current Care Plans of failed to indicate a plan for care of the skin related to the boil on the resident's left thigh.<br><br>Documentation on the Medication Record for February 2011 indicated the treatment ordered for the boil on Resident D's left thigh was planned once on the 6:00 a.m. to 2:00 p.m. shift and once on the 2:00 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | p.m. to 10:00 p.m. shift. The record indicated the treatment was administered only one time instead of two times on 2/27/11.<br><br>Documentation on the Medication Record for March 2011 indicated the treatment was planned as in February 2011. The record indicated the treatment was administered only one time instead of two times on 3/7/11.<br><br>On 3/9/11 at 12:50 p.m., LPN #6 was observed providing the treatment to Resident D's left thigh. LPN #6 gathered supplies including a washcloth, tube of triple antibiotic ointment, packaged Telfa pad, and tape and went to the resident's room. LPN #6 donned disposable gloves when Resident D's roommate requested assistance with her slippers. LPN #6 assisted the roommate with her slippers, and the roommate requested to be wheeled from the room. LPN #6 wheeled her out and returned to the room. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | She removed the disposable glove, and without washing her hands, donned another pair. She took the washcloth to the resident's bathroom and wet it. Resident D pulled her pants below the knees, and the dressing on the left thigh indicated 3/8/11, 8:15 p.m. LPN #6 removed the soiled dressing. The resident indicated the wound was itching, but "I know not to touch it." The resident indicated, "It looks like it's filling back up." LPN #6 applied the washcloth to the leg, and the resident stated, "I remember when I was young, we would use a hot compress." LPN #6 removed her gloves and without washing her hands donned another pair. The nurse knelt beside the resident, and the packaged Telfa and tape were placed on the floor. The nurse removed the washcloth from the resident's leg and indicated there was no drainage. The wound was observed to be white/yellow in the center surrounded by a red rim and dark around the edges under the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | skin. During interview at this time, LPN #6 indicated documentation should be in the record about the wound size, and she indicated she estimated the current size by placing her thumb to the first knuckle of her middle finger to show the approximate size of the wound. LPN #6 dispensed the triple antibiotic ointment onto her glove and then the wound, and placed the tube of ointment onto the leg/foot of the resident's overbed table. She then applied the dressing, taped it, and wrote "3-9-11 [her initials] 6-2" and drew a smiley face on the dressing.<br><br>During interview on 3/9/11 at 2:30 p.m., the DON indicated the facility did not have written wound care policies. She indicated related to assessment of the wound that a nurse would write what she sees. The DON showed a Weekly Wound Evaluation Flow Record for another resident and indicated she would expect to see the information there | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | on a wound assessment. Review of the Flow Record indicated information including stage, length, width, and depth, presence of undermining, exudate type and amount, tissue description, and surrounding skin color and type. The DON indicated the facility did not have a specific policy related to how to do a clean dressing change, and asked for the identification of the resident whose dressing change was observed, so she could "educate the nurse."<br><br>During interview on 3/9/11 at 4:45 p.m., the DON indicated she had spoken with a nurse, who told the DON she had measured the resident's wound when it was first noted, but forgot to write it down. The DON indicated she could find no documentation to indicate the wound had been assessed since 2/17/11. The DON indicated she could not find a Weekly Wound Evaluation Flow Record for Resident D's wound. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 2. The clinical record for Resident G was reviewed on 3/8/11 at 9:40 p.m. The resident's diagnoses included, but were not limited to, unspecified peripheral vascular disease and unspecified venous insufficiency.<br><br>Weekly Skin Check Sheets for February and March 2011 indicated the following: on 2/5, 2/12, and 2/26/11, the assessment indicated the resident had "Open area: Old." Documentation failed to indicate a skin assessment was completed on 2/19/11. Documentation on 3/5/11 indicated "Skin Intact." Weekly Wound Evaluation Flow Records from 1/19/11 through 3/9/11 indicated the resident was being treated for a non-pressure ulcer to the left ankle.<br><br>A physician's order was received on 2/22/11 for "Cleanse R [right] ankle [symbol for with] NS [normal saline] apply Aquacel AG [alginate] | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | cover [symbol for with] Versiva X C & wrap [symbol for with] Kerlix q [every] 3 days & PRN [as needed] for soiled/dislodged."<br><br>Documentation in Nurse's Notes from 2/22/11 through date of review or on a Weekly Wound Evaluation Flow Record failed to indicate a description of the wound.<br><br>Documentation on the Medication Records for February and March 2011 next to the entry for the dressing change to the right ankle indicated the dressing was changed on the following dates: 2/22, 2/25, 2/26, and 2/28/11 and 3/3, 3/5, 3/6, and 3/7/11.<br><br>Nurse's Notes for 2/25/11 at 1:20 p.m., indicated, "...Tx [treatment] to bilat [bilateral] ankles completed as ordered." No other Nurse's Notes indicated information about the wound to the right ankle.<br><br>The resident's Health Care Plan | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | indicated a problem of "Venous Stasis Ulcer to the left ankle," dated 2/3/10, with most recent Goal date of 1/26/11. Documentation failed to indicate a plan related to care of the right ankle.<br><br>During interview on 3/9/11 at 4:45 p.m., the DON researched the resident's record for information about the wound. LPN #3 was seated at the nurse's station and indicated the resident had wounds come and go on both ankles with lots of changes in treatments. The DON telephoned the nurse, LPN #12, who had cared for Resident G on day shift on 3/9/11. LPN #12 indicated to the DON she provided a treatment to the resident's left ankle today but did not provide the treatment to the right ankle, because there was "nothing to treat." The DON asked LPN #12 if she had obtained a physician's order to discontinue the treatment, and LPN #12 indicated she had not contacted the physician. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Resident G's right ankle was observed on 3/9/11 after the DON completed the phone conversation with LPN #12. The DON and LPN #3 wheeled the resident to his room and removed his white sock. Two small areas of bright red blood were on the sock. The resident's lower right leg was dark red, and the skin was shiny. Two open areas oozing clear bloody fluid were observed on the front of the right shin. A dark purplish blotch under the skin was observed on the top of the foot. No dressing was present on the resident's right ankle. The top of the outer malleolus had a dull dark red center that appeared firm and slightly depressed. No drainage was observed. LPN #3 ran her fingers over the area and indicated it was not open. The resident asked if there was pus in the wound, and LPN #3 told him there was not. LPN #3 indicated she would obtain treatment orders and care for the two new wounds on the resident's | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | shin.<br><br>This federal tag relates to Complaint IN00086657.<br><br>3.1-37(a) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0441 SS=F | Based on observation, interview, and record review, the facility failed to implement the policies and procedures of its infection control program related to collecting, analyzing, and acting on infection control data. This deficient practice had the potential to affect 74 of 74 residents residing at the facility. The facility also failed to ensure staff followed policy for handwashing and glove use and dressing supplies during dressing change for 1 of 2 observations of wound care. (Resident D) The facility also failed to ensure implementation of procedure of identification in clinical records related to isolation precautions for 4 of 4 residents reviewed related to isolation precautions in a sample of 7. (Residents C, E, G, and H)<br><br>Findings include:<br><br>1. On 3/9/11 at 12:30 p.m., the Director of Nursing (DON) was requested to provide policy and | F0441 | **F441 483.65 (a) INFECTION CONTROL PROGRAM**<br><br>It is the practice of Landmark Nursing and Rehabilitation to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and the help prevent the development and transmission of disease and infection.<br><br>I. The DON was provided with and educated on current Infection Control Policies & Procedures by corporate nurse consultant. Infection Control logs were updated to reflect infectious processes present in the facility from January 1, 2011 to March 22nd by corporate nurse consultant. This log will be updated daily as infections are identified by DON or designee. Monthly Infection Report for All Nursing Units was completed for January and February 2011 by corporate nurse consultant. No trends were identified. Isolation stickers were placed on the charts for Resident C & G. Resident's E and H no longer require isolation. Resident D has been assessed and shows no signs or symptoms of infection. Care plans for Resident C, D, G, E and H have been reviewed and updated to include current infection control needs.<br>II. All residents were | 04/08/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | procedure related to the facility's infection control program and documentation related to the facility's collecting, analyzing, and acting on infection control information, such as infection control logs.<br><br>On 3/9/11 at 12:50 p.m., the DON showed a binder containing print-outs from the facility's lab provider indicating lab results for specimen cultures with dates from 12/1/10 through 2/28/11. The print-outs indicated the information was faxed from the lab to the facility on 3/4/11. At this same time, the DON indicated the facility received this information to help in implementation of the company-wide new Infection Control Program, which began in January 2011. The DON also provided copies of blank forms with revision date of 10/2010, which the DON indicated would be used for gathering and analyzing data related to infections in the | | reviewed for the presence of infection. Those residents with identified infections were placed on the Infection Control Log. Physician's orders were reviewed and found adequate to treat currently identified infections. Those residents with infections requiring isolation were reviewed. Stickers were placed on charts and care plans were updated.<br>III. Infection Control Policies and Procedures were reviewed by QA and found to be appropriate. All staff will be reeducated on infection control policies. Clean Dressing Change Policy was reviewed by QA and found to be appropriate. LPN #6 will receive 1:1 reeducation on clean dressing changes including but not limited to use of PPE and hand washing. Nurses will be reeducated on Clean Dressing Change Policy. The DON was provided with and educated on current Infection Control Policies & Procedures by corporate nurse consultant. Infection Control logs were updated to reflect infectious processes present in the facility from January 1, 2011 to March 22nd. This log will be updated daily as infections are identified. Monthly Infection Report for All Nursing Units was completed for January and February 2011. This report will be completed monthly by DON or designee. A competency checklist for Clean Dressing Changes was drafted | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | facility. The forms were month by month reports and included information including, but not limited to, resident name, room number, signs and symptoms, physician diagnosis, culture results, and comments for infections of the skin, including cellulitis/soft tissue wounds, fungal skin infections, herpes simplex, herpes zoster, and scabies; gastrointestinal tract infections; eye, ear, nose, and mouth infections; systemic infections, including common cold syndrome and influenza-like illness; and urinary tract infections, including with and without catheter. Also included was a summary type form entitled, "Monthly Infection Report for All Nursing Units" with columns for breakdown by unit of the various types of infections. At this time, the DON was requested to provide the tracking since prior to use of the new documents.<br><br>During interview on 3/9/11 at 2:30 | | and approved by QA.<br>IV. DON or designee will update Infection Control Log daily. QA will review Infection Control Log weekly for four weeks, monthly for two months and then quarterly. DON or designee will complete Monthly Infection Control Report for All Nursing Units monthly. QA will review this report monthly for three months and then quarterly. The DON or designee will complete Clean Dressing Change Competency Checklists with all nurses initially and then no less often than annually thereafter.<br>V. COMPLETION DATE: 04/08/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | p.m., the Director of Nursing again indicated the facility was in process of implementing a company-wide Infection Control Program which started at the first of the year, 2011. At this time, the DON provided copies in the of print-outs she indicated were provided to her by the facility's laboratory provider. The copies indicated run dates for 9/1/10 through 2/28/11. The DON indicated she had highlighted the months by specimen collection date for the specimen cultures obtained. She indicated use of the data collection forms provided by the facility's parent company had not been implemented. She also indicated an Infection Control Committee had not met to analyze and act on the data provided by the lab for the months since September 2010.<br><br>Review of the facility's "Policies and Practices - Infection Control," provided on 3/9/11 at 2:30 p.m., by the DON, who indicated the policy | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | was in effect since 1/1/11, indicated, "2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility.... 3. The Quality Assessment and Assurance Committee, through the Infection Control Committee, shall oversee implementation of infection control policies and practices....6. Inquiries concerning our infection control policies and facility practices should be referred tot he Infection Control Coordinator or Director of Nursing Services.<br><br>2. Review of the facility's "Multidrug-Resistant Organisms," provided on 3/9/11 at 2:30 p.m., by the DON, who indicated the policy was in effect since 1/1/11, indicated: "...9. Should a resident be placed on Contact Precautions implement the following: ...f. Place facility-specific sign/stickers on the door, and on the chart...." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | During Initial Tour of the facility on 3/8/11 at 6:50 p.m., signs indicating "STOP - REPORT TO NURSE BEFORE ENTERING" were observed on the doors of the rooms of Residents G, E, and H. The sign was also posted on the top of a plastic drawer bin outside the room of Resident C.<br><br>During interview on 3/8/11 at 8:25 p.m., LPN #9 indicated Resident C was on Contact Precautions due to drainage from a wound to the back that was MRSA (methecillin resistant staphylococcus aureus) positive. During the same interview, when asked about the sign on the door of Resident G, LPN #9 pulled a chart from the chart rack. The chart was for Resident G's roommate. The nurse paged through many pages of the chart and indicated, "I'm finding out all kinds of things here, but not seeing here what I'm looking for." At 8:35 p.m., the Assistant Director of Nurses indicated the STOP sign | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | on Resident G's door was related to Resident G's care.<br><br>A. The clinical record for Resident G was reviewed on 3/8/11 at 9:40 p.m. The record failed to indicate a sticker on the chart to alert staff to the resident's isolation precautions.<br><br>B. The clinical record for Resident E was reviewed on 3/8/11 at 9:30 p.m. The record failed to indicate a sticker on the record to alert staff to the resident's isolation precautions.<br><br>C. The clinical record for Resident C was reviewed on 3/8/11 at 9:10 p.m. The record failed to indicate a sticker on the record to alert staff to the resident's isolation precautions.<br><br>D. The clinical record for Resident H was reviewed on 3/9/11 at 5:30 p.m. The record failed to indicate a sticker on the chart to alert staff to the resident's isolation precautions.<br><br>During interview on 3/9/11 at 4:00 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | p.m., the DON indicated she would need to "sit and go through" the chart to determine information related to a resident's isolation precautions. She indicated the chart did not have a standard place to look for the information.<br><br>3. On 3/9/11 at 12:50 p.m., LPN #6 was observed providing the treatment to Resident D's left thigh. LPN #6 gathered supplies including a washcloth, tube of triple antibiotic ointment, packaged Telfa pad, and tape and went to the resident's room. LPN #6 donned disposable gloves when Resident D's roommate requested assistance with her slippers. LPN #6 assisted the roommate with her slippers, and the roommate requested to be wheeled from the room. LPN #6 wheeled the resident out and returned to the room. She removed the disposable gloves, and without washing her hands, donned another pair. Resident D pulled her pants below the knees, and LPN #6 removed | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the soiled dressing. LPN #6 removed her gloves and, without washing her hands, donned another pair. The nurse knelt beside the resident, and the packaged Telfa and tape were placed on the floor. LPN #6 dispensed the triple antibiotic ointment onto her glove and the wound, and placed the tube of ointment onto the leg/foot of the resident's overbed table. She then applied the dressing, taped it, and wrote "3-9-11 [her initials] 6-2" and drew a smiley face on the dressing. The nurse removed her gloves and, without washing her hands, left the room.<br><br>On 3/9/11 at 2:10 p.m., the Administrator provided policies she indicated are used in orientation to train employees related to infections control. Review of the policies indicated information related to personal protective equipment (PPE), including gloves. The information indicated, "Always perform hand hygiene immediately | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | before donning and after removing PPE."<br><br>During the interview on 3/9/11 at 2:30 p.m., the DON indicated the facility did not have a specific policy related to how to perform a clean dressing change, and asked for the identification of the resident whose dressing change was observed, so she could "educate the nurse."<br><br>This federal tag relates to Complaint IN00086657.<br><br>3.1-18(b)(1)(A)<br>3.1-18(b)(2)<br>3.1-18(l) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0514 SS=D | Based on record review and interview, the facility failed to ensure the resident's record was accurate related to care in the event the resident's heart or breathing stopped. The deficient practice affected 1 of 1 resident reviewed related to code status in a sample of 7. (Resident D)<br><br>Findings include:<br><br>The clinical record for Resident D was reviewed on 3/8/11 at 10:55 p.m.<br><br>Taped inside the front cover of the record was a yellow sticky note which indicated, "DNR [do no resuscitate] status 1/20/2011."<br><br>The physician's orders for 2/1/11 through 2/28/11 and 3/1 through 3/31/11 included, but were not limited to, "Code status: Full code."<br><br>In the Advance Directives section | F0514 | **F514 RESIDENT RECORDS-COMPLETE/ACCURATE/ACCESSIBLE**<br><br>It is the practice of Landmark Nursing & Rehabilitation to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>I. Resident D's clinical record was reviewed. A sticker was placed on the chart indicating "DNR" status. Resident D's physician was contacted and orders were received for "DNR" status as indicated in Resident D' s advance directives. Resident D' s care plan was updated to reflect current code status.<br>II. All residents' records were reviewed for advance directives. All residents' physician's orders were reviewed and new orders were received as necessary to reflect residents advance directives. Stickers for those residents opting for "DNR" status were placed on charts. All resident care plans were reviewed and updated to reflect current code status.<br>III. Advance Directives Policy was reviewed by QA and found to be appropriate. Nurses, C.N.A.'s and Care Plan Coordinator will be reeducated on | 04/08/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155616 | A. BUILDING _____ B. WING _____ | 03/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | of the record was a Code Classification Form with a check mark in the box for: "No Code. C.P.R. [cardiopulmonary resuscitation or basic life support] will not be initiated." A signed physician's order dated 1/20/11 at 3:00 p.m., was attached to the form and indicated, "DNR."<br><br>The Care Plan Worksheet, dated 1/14/11, indicated, "The resident's code status has been designated as a FULL CODE."<br><br>During interview on 3/9/11 at 4:00 p.m., the Director of Nursing indicated, "We've been working on the code status in the records."<br><br>3.1-50(a)(2) | | policy<br>IV. The Care Plan Coordinator will review each resident's care plan no less often than quarterly. This review will include but not be limited to Code Status. Care plans will be revised as necessary to assure the current reflection of each resident's code status and stickers placed on the clinical record as appropriate. Physician Order Sheets will be reviewed monthly by DON or designee. This review will include but not be limited to Code Status. New orders will be received and reflected on the Physician's Order Sheets as necessary to reflect each resident's current code status. All new orders will be reviewed by IDT daily. This review will include but not be limited to code status, stickers and care plans. The DON or designee will report to QA monthly for 3 months and then quarterly.<br>COMPLETION DATE: 04/08/2011 | |